



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Quality of Care Concerns  
and the Facility Response  
Following a Medical  
Emergency at the VA  
Southern Nevada Health  
Care System in Las Vegas



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the care provided to a patient who died after a fall in a VA outpatient clinic (clinic), part of the VA Southern Nevada Healthcare System, Las Vegas, Nevada. The OIG received an inquiry from Senators Catherine Cortez Masto and Jacky Rosen in response to a media story that aired in May 2022, with video of an incident in late spring 2021 in which a patient died following an alleged delay in staff providing intervention and care at the clinic.<sup>1</sup>

During the inspection, the OIG identified concerns related to the quality of care provided to the patient in the days prior to and at the time of the incident. Additional concerns included leaders' response to the incident and staff knowledge of the processes in place for advance healthcare planning with patients.<sup>2</sup>

### Patient Case Summary

The patient was in their 80s with a medical history remarkable for obstructive [sleep apnea](#), high blood pressure, chronic kidney disease, [hyperlipidemia](#), severe [coronary artery disease](#), and heart failure.<sup>3</sup> Since 2018, the patient was followed by a specialist at the facility and primary care providers in the clinic. In late summer 2018, the patient declined a recommended heart surgery and declined medical therapy for hyperlipidemia. A primary care provider (PCP 1) recorded that, in the event of an emergency, the patient did not want [cardiopulmonary resuscitation](#) (CPR) and advised that the patient “complete [[advance directive](#)]” to clarify wishes. The patient submitted a completed advance directive several days later, which was scanned into the patient’s electronic health record (EHR). PCP 1 did not enter a [life-sustaining treatment](#) plan or order into the EHR to formalize the patient’s wish for no CPR.

The patient had regular primary care clinic appointments from 2018 through 2021 and continued to take two blood pressure medications for blood pressure control. In a telehealth visit in early 2021, another primary care provider (PCP 2) recorded that the patient was “doing well. No recent episodes of dizziness or falls” and instructed the patient to continue blood pressure medications as prescribed. In late spring 2021, the patient presented to the clinic for a nursing same-day access visit. The nurse who saw the patient recorded that the patient said the blood pressure control medication “is making [the patient] feel dizzy, patient states when [the patient]

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<sup>1</sup> In summer 2021, the OIG received an allegation regarding the VA clinic in which a nurse failed to assess a patient’s “condition in a timely manner resulting in a delay for CPR and the AED” but the OIG was unable to review the complaint due to an inability to identify the patient at that time.

<sup>2</sup> The OIG uses the term ‘incident’ to identify the patient’s fall and subsequent death in late spring 2021.

<sup>3</sup> The OIG uses the singular form of they (their) in this instance for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

takes the medication it makes it feel like the room is spinning.” The nurse advised the patient “to keep [the] appointment [four days later] and discuss [the] medication then.” The nurse did not record a set of vital signs at this visit. The nursing note was cosigned the same day by the most recently assigned primary care provider (PCP 3).

The patient presented to the clinic for the scheduled follow-up appointment four days later. On intake, a licensed practical nurse noted that the patient was “winded when ambulating, has unsteady [gait](#) and needs walker for assistance.” The patient’s vital signs that were documented were normal with the exception of an elevated pulse of 105.<sup>4</sup> [Orthostatic vital signs](#) were not documented.<sup>5</sup> The licensed practical nurse recorded the patient’s report of four falls in the past year, most recently the prior month.

During the clinic visit with PCP 3 on the day of the incident, the patient relayed having symptoms of dizziness on and off for the prior four weeks and reported stopping one of the medications for blood pressure control with some improvement of the dizziness. The patient also complained of swelling in both feet. The patient’s roommate provided additional history to PCP 3 via telephone during this visit, stating that the patient had fallen at home about six times in the past month and had occasional difficulty with memory recently. PCP 3 reviewed blood work results from blood taken five days earlier; ordered a chest x-ray, repeat blood work, and documented a plan to order imaging of the brain; and referred the patient to the falls prevention clinic. The patient was scheduled for a primary care follow-up visit in three months and PCP 3 accompanied the patient to the clinic door that leads to the lobby.

Later in the day, PCP 3 added an addendum to the EHR that stated the patient had been escorted to the clinic door after the visit and “ambulated with [a] walker without any difficulty.” PCP 3 documented “responding to an emergency call” in the lobby and found “the patient was [being] resuscitated by clinic staff and 911 crew.”

The following day, a facility community care nurse entered an EHR note summarizing the timeline of events after the patient fell. The note also documented that after discussion with the family, resuscitative efforts were terminated, and the patient was pronounced dead.

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<sup>4</sup> Mayo Clinic, “What’s a normal resting heart rate?” accessed October 6, 2022, <https://www.mayoclinic.org/healthy-lifestyle/fitness/expert-answers/heart-rate/faq-20057979#:~:text=A%20normal%20resting%20heart%20rate%20for%20adults%20ranges%20from%2060,to%2040%20beats%20per%20minute.> “A normal resting heart rate for adults ranges from 60 to 100 beats per minute.”

<sup>5</sup> The licensed practical nurse reported to the OIG not taking a set of orthostatic vital signs because there was no request from the PCP that they be done.

## Delayed Response to the Medical Emergency and Quality of Care Concerns

Documentation in the patient's EHR shows that in 2018, the patient requested no CPR based on a contemplated surgical procedure at that time. The patient's EHR, however, lacked an order formalizing the patient's wish for no CPR. Therefore, staff were obligated to initiate CPR if clinically warranted. The OIG substantiated that staff's initiation of CPR on the day of the patient's death was delayed.

The OIG determined that failures in response to the medical emergency included ineffective emergency notification speakers to activate the emergency response, and incomplete incident documentation and review. The OIG also identified quality of care concerns that included PCP 3 evaluating the patient on the day of the incident but not further evaluating the cause of the patient's dizziness and elevated heart rate. In addition, the OIG found that four days prior to the incident, a clinic nurse care manager did not evaluate the patient's reports of dizziness.

### Delayed Initiation of CPR

The OIG substantiated that a nurse delayed initiating CPR for the patient after establishing the patient did not have a pulse and was not breathing. Veterans Health Administration (VHA) policy requires clinical staff to attempt CPR on every patient who sustains cardiopulmonary arrest unless specific criteria are met, including a documented order to not resuscitate or the patient having given unequivocal instructions to not perform CPR.<sup>6</sup> The American Heart Association Basic Life Support (BLS) course instructs healthcare providers to assess for breathing and a pulse, and if no breathing and no pulse is present, to initiate CPR followed by use of an [automated external defibrillator](#) (AED) as soon as it is available.<sup>7</sup>

The OIG reviewed the video of the patient's fall and subsequent response by clinic staff and, using a combination of observations, interviews, the patient's EHR, and review of facility documents, made determinations regarding the expediency of the care provided. On video, a visitor and a VA police officer (Officer 1) initially responded to the patient, and approximately two and a half minutes after the patient fell, a nurse (Nurse 1) walked towards the patient with a portable vital signs machine. The patient was on the ground when Nurse 1 bent over and placed a [pulse oximeter](#) on the patient's finger, stood up, and stepped back towards the vital signs machine.

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<sup>6</sup> VHA Handbook 1004.03(2), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017, amended May 10, 2021. The handbook was in effect during the time of the events discussed in this report; and was amended September 28, 2022. VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, amended May 26, 2017.

<sup>7</sup> American Heart Association, *Basic Life Support-Provider Manual*, October 2020.

During an interview, Nurse 1 told the OIG the pulse oximeter did not detect a pulse. The nurse bent over again, placed a hand on the patient's chest, and then moved the fingers towards the patient's neck, such as to check for a pulse. Nurse 1 stood up, stepped back, pointed towards the wall where the AED was located, and Officer 1 returned with the AED roughly twenty seconds later. A nurse practitioner arrived and assisted with placing AED pads on the patient's chest. Approximately two minutes after Nurse 1 responded, Nurse 2 arrived on the scene, felt for a pulse, and started CPR. Approximately four and a half minutes after the patient's fall, CPR was started. Clinic staff continued CPR until emergency medical services arrived and assumed care of the patient. The patient was transferred to a community hospital emergency room and was pronounced dead.

In further assessing the incident timeline, the OIG determined that at the point in time when Officer 1 interacted with the patient, the patient was responsive and therefore, Officer 1 would not have been expected to initiate CPR. The OIG was unable to determine the exact time the patient ceased to have a pulse because it could not be validated on the video and there was no documentation for review. However, the OIG substantiated that Nurse 1, who was BLS certified and had confirmed a lack of oxygen saturation and blood pressure on the initial assessment of the patient, did not initiate CPR. Nurse 1 described being concerned that doing chest compressions might have worsened the head injury but acknowledged to the OIG that upon reflection, CPR should have been started sooner. The OIG was unable to determine if the delay in initiating CPR led to the patient's death.

### **Ineffective Emergency Notification Speakers**

The OIG determined that, although required by facility policy, the clinic's overhead speakers for activating the emergency response had not been working and there were difficulties with hearing the overhead speakers throughout the clinic before and at the time of the incident.<sup>8</sup>

During interviews, a patient safety coordinator, former clinic nurse manager, and emergency manager each confirmed difficulties with the overhead speakers. Two nursing staff, at the time of the incident, also confirmed difficulty hearing the overhead speakers. The patient safety coordinator added that since the clinic is in a leased building, engineering staff were working with a non-VA site manager to have them repaired. A former clinic nurse manager reported to the OIG that some staff had a portable phone system that could be used to communicate with one another; however, this tool was not accessible to all clinic staff. The facility emergency manager reported to the OIG that the best way to make notification at the time of the incident was by

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<sup>8</sup> MCP 11-20-34, Management of Medical Center Emergencies at Off-Site Medical Center Locations, September 2, 2020.

word of mouth. Staff reported word of mouth and instant messaging were utilized for notification of the incident but that the urgency was not indicated.

Since the incident, staff reported actions taken to improve education, messaging, and guidance for use of the overhead speakers. While on-site in early August 2022, the OIG was present when an emergency occurred in the lobby and was announced on the overhead speakers. The OIG heard the announcement and observed staff appropriately responding with the AED and medical supplies. However, later in the day, the OIG was informed of another code that was announced overhead but not heard by OIG staff. The OIG noted clinic areas where the overhead speakers were difficult to hear and concluded that while significant improvements have been made to emergency response processes, the notification for staff via overhead speakers is an important tool for immediate response by clinical staff that continues to have limitations.

### **Establishment of Scene Safety**

The OIG determined safety at the scene of the incident was established. One of the initial steps in BLS is to establish scene safety, which includes “siz[ing] up” the scene of an incident to “ensure there is a safe scene on which to provide care,” with the goal being “to protect patients from unsafe conditions, but also to prevent responders and bystanders from becoming patients and requiring additional scene resources.”<sup>9</sup>

Staff reported concerns regarding the management of the visitors in the lobby who were visible in the video. The OIG concluded that police officers recognized that scene safety was required; however, they were unable to focus solely on addressing the management of the other visitors, patients, and family members in the area until additional staff arrived to care for the patient who fell. The facility conducted subsequent emergency response training and OIG staff observed effective emergency notification and the orderly and timely staff response to a later on-site emergency. VA police at the facility must continue to be properly trained on emergency responses, including securing the scene.

### **Incomplete CPR Documentation and Review**

The OIG determined that staff did not complete the proper documentation of the incident that would trigger awareness of the incident by the CPR committee. Therefore, the incident was not reviewed by the CPR committee, as required.

Although the CPR committee was responsible for reviewing inpatient and outpatient events, the chair reported that the committee did not review the incident as there was no CPR form

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<sup>9</sup> Emmons J, Cooney DR. Scene Safety and Size-Up. In: Cooney DR. eds. *Cooney's EMS Medicine*. McGraw Hill; 2016, accessed September 30, 2022, <https://accessemergencymedicine.mhmedical.com/content.aspx?bookid=1650&sectionid=107954512>.

completed for submission to the committee. A clinical staff member at the scene is to document specific information regarding the patient and incident, the patient's condition such as vital signs and cardiac rhythm, a sequence of events of any treatments provided, and the patient's final disposition on the CPR record form.<sup>10</sup> The OIG did not find evidence of a completed CPR record form for the patient's incident. Documentation was limited to a progress note written by the nurse practitioner who responded to the incident and an EHR entry made by PCP 3. Both nurses who responded to the incident told the OIG that they did not document anything after the patient's incident; one nurse noted thinking someone else documented and the other nurse explained being "in shock."

### **Inadequate Patient Assessment and Management**

The OIG reviewed the care provided to the patient immediately preceding and four days prior to the incident and found these appointments presented potential opportunities for additional assessment of the patient's symptoms.

PCP 3 evaluated the patient on the same day as the incident and was aware of a note entered by the clinic nurse care manager four days prior but did not further evaluate the cause of the patient's dizziness and elevated heart rate. The OIG concluded that, given the patient's presentation, PCP 3 could have ordered additional tests to be completed at the time of the patient's evaluation, such as orthostatic vital signs or an [electrocardiogram](#). However, the OIG is unable to determine if ordering such additional tests would have changed the patient's clinical course.

The clinic nurse care manager who saw the patient four days prior to the incident did not take vital signs or refer the patient for a same-day assessment by a provider because the patient was "not actively having symptoms" and was not "acutely in distress." The OIG would have expected the nurse care manager to evaluate the patient's reported dizziness symptoms, such as taking the patient's vital signs, consulting with a physician, or referring the patient for assessment by a provider that day.

### **Facility Leaders' Response to the Incident**

The OIG determined that facility leaders' reviews of the incident were limited by the lack of information documented in the EHR, and that decisions were made based upon an unconfirmed determination of the patient's cause of death.

The OIG found that in response to the incident, facility leaders conducted an emergency management debrief and promptly completed an after-action review. The emergency preparedness manager reported that the debrief was conducted two days after the incident and the

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<sup>10</sup> MCP 11-20-34.

staff documented as participating included primary care, nursing, business administration services, police, patient safety, social work, and site leaders. Participants discussed what occurred and potential improvements. The OIG concluded that corrective actions developed as a result of the debrief were sufficient to address the identified deficiencies and that education provided to clinic staff regarding emergency response, including command and control and CPR, has been effective in changing processes. However, monitoring is needed to ensure ongoing compliance and sustainability of the processes.

The OIG also found that facility and patient safety staff utilized the patient safety reporting system to review the incident, as required.<sup>11</sup> After an incident is reported in this system, Quality, Safety and Value (QSV) staff assign a safety assessment code score to the incident based on the severity of the incident and the probability of it happening again. The OIG concluded that reliance on an unconfirmed determination of the patient's cause of death impacted the final score QSV leaders gave to the incident. As a result, facility staff did not do an in-depth review of the incident using a [root cause analysis](#), which prevented assessment of other potential factors contributing to the incident, and staff response.<sup>12</sup> Rather, to address the incident, facility leaders relied on a review of the emergency response process that did not focus on clinical emergency procedures or patient safety. However, as the actions completed as a result of the review addressed the clinic's process gaps specific to this incident, the OIG did not make a recommendation.

The OIG determined that due to the seriousness of the incident and unconfirmed cause of death, an [institutional disclosure](#) was warranted but did not occur. The Chief of Staff reported that while viewing the video, there was a lack of certainty as to when the patient became pulseless and CPR should have been initiated, but response could have been better. When asked, the Chief of Staff and chief of QSV told the OIG that an institutional disclosure was not done as the patient experienced a physiologic event (cardiac event leading to fall and injury) associated with their known medical conditions. The OIG concluded that the incident that occurred at the clinic ended with the patient's death and based on the severity of the incident and the delayed initiation of

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<sup>11</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Program*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding patient safety reporting and root cause analysis as the 2011 handbook. VHA National Center for Patient Safety, *2020 JPSR Business Rules and Guidebook*, July 2020. This guidebook was in place during the time of the events discussed in this report. It was rescinded and replaced by *VHA Guidebook for JPSR Business Rules and Guidance*, November 2021. The two guidebooks have the same or similar language related to the classification of deaths related to SAC scoring. VHA uses a patient safety event reporting system and database called the Joint Patient Safety Reporting (JPSR) System. The patient safety reporting system is a user-based system where staff enter information related to unsafe conditions, adverse events, and close calls.

<sup>12</sup> VHA Handbook 1050.01. Root cause analysis is a "process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events."

CPR, a discussion with the patient’s next of kin or designated significant other regarding the potential causes of the delay and actions taken to prevent a similar occurrence was warranted.

Peer reviews are another tool available to review care following an incident. VHA defines peer review for quality management as “a critical review of care performed by a peer” to include “identification of learning opportunities for practice improvement and any related improvement actions recommended.”<sup>13</sup> The primary focus of peer review is to determine whether the “clinical decisions and actions of a clinician during a specific clinical encounter met the [standard of care](#).”<sup>14</sup> The OIG confirmed the completion of two peer reviews addressing the care provided during the same-day access appointment four days prior to the incident, and the primary care visit on the same day as, but prior to, the incident. According to the staff interviewed, the scope and value of peer reviews were impacted by the limited information documented in the EHR, and facility staff’s claims of reviewers’ inability to review video recordings to assist reviewers in understanding the clinical decision-making. Although the OIG does not find that this precludes a peer review in every instance, given that the facility addressed issues relating to nursing staff’s failure to follow CPR protocols by retraining staff, the OIG did not make a recommendation related to peer reviews.

Facility policy states that the Chief of Staff and Associate Director Patient Care Services are responsible for monitoring the quality and safety of clinical medical practice and clinical nursing practice, respectively, within the facility.<sup>15</sup> The chief of QSV serves as a consultant to medical center leadership for quality and patient safety.<sup>16</sup> The OIG found that the Chief of Staff, Associate Director Patient Care Services, and chief of QSV each independently reviewed the patient’s EHR; however, the leaders’ reviews were limited due to lack of documentation specific to the incident, including CPR efforts.<sup>17</sup> As a result, these reviews did not trigger, nor were they part of, any formal quality management review processes that may have improved documentation of the incident.

## **Staff’s Understanding of Advance Care Planning**

During the inspection, the OIG identified a deficiency in staffs’ understanding of advance care planning policies and procedures.<sup>18</sup> While staffs’ lack of understanding of advance care planning policies and procedures may not have resulted in a different outcome for this patient, the OIG

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<sup>13</sup> VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

<sup>14</sup> VHA Directive 1190.

<sup>15</sup> Medical Center Memorandum 00-19-35, *Organizational Framework for Quality, Safety, and Value*, June 2019.

<sup>16</sup> MCM 00-19-35.

<sup>17</sup> The Chief of Staff indicated reviews were completed after the incident was released by the media in 2022.

<sup>18</sup> For this report, the OIG considers advance care planning to include discussions and documentation about patients’ values, goals, and preferences, including advance directives and life-sustaining treatment decisions.

identified this incident as an opportunity for facility and primary care leaders to assess staff knowledge of the advance care planning process, advance directives, and life-sustaining treatment decision processes, identify gaps, and develop actions accordingly.

In conclusion, the OIG made five recommendations to the Facility Director related to ensuring proper outpatient clinic emergency processes, ensuring compliance with CPR documentation, ensuring after-action plans are completed and monitored, determining if an institutional disclosure is warranted, and evaluating and addressing staffs' understanding of advance care planning.

## **VA Comments and OIG Response**

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, VHA provided technical comments to the OIG during the draft phase. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings and recommendations.

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General  
for Healthcare Inspections

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## Abbreviations

AED	automated external defibrillator
BLS	basic life support
CPR	cardiopulmonary resuscitation
EHR	electronic health record
MSA	medical support assistant
OIG	Office of Inspector General
PACT	patient aligned care team
PCP	primary care provider
QSV	Quality, Safety, and Value
SAC	safety assessment code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the care provided to a patient who died after a fall in a VA outpatient clinic, part of the VA Southern Nevada Healthcare System, Las Vegas, Nevada.

## Background

The VA Southern Nevada Healthcare System (facility) in Las Vegas, Nevada, is part of Veterans Integrated Service Network (VISN) 21 and is designated as a level 1b, high complexity system.<sup>1</sup> The North Las Vegas VA Medical Center has 130 operating hospital beds providing medical, surgical, and mental health services. The facility has seven outpatient clinics in Nevada: Northeast, Northwest, Southeast, Southwest, and West Cheyenne in Las Vegas; Laughlin; and Pahrump.

The Northeast Primary Care Clinic (clinic) is located in Las Vegas, Nevada, approximately 11 miles from the medical center, and provides primary and specialty care, including mental health, audiology, laboratory, pathology, and radiology services.<sup>2</sup>

## Basic Life Support

According to the American Red Cross, “Basic Life Support, or BLS, generally refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing [cardiac arrest](#), respiratory distress or an obstructed airway.”<sup>3</sup> The American Heart Association BLS course offers instructions on how to perform high-quality [cardiopulmonary resuscitation](#) (CPR) in a variety of settings, and how to respond to life threatening emergencies including choking. Individuals who have completed a BLS course should know the BLS concepts of the chain of survival, recognize the symptoms of someone needing CPR, perform high-quality CPR, use an [automated external defibrillator](#) (AED), and

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<sup>1</sup> The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with level 1a facilities being the most complex and level 3 facilities being the least complex. A level 1b high complexity facility has “medium high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs.”

<sup>2</sup> The Northeast Primary Care Clinic services do not include an emergency department, although urgent care appointments are offered.

<sup>3</sup> American Red Cross, “What is BLS?” accessed October 6, 2022, <https://www.redcross.org/take-a-class/performing-bls/what-is-bls>. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

provide “effective ventilations using a barrier device.”<sup>4</sup> The steps in BLS direct healthcare providers to

- “verify scene safety,”
- “check for responsiveness” and “if the victim is not responsive, activate the emergency management response system,”
- “assess for breathing and a pulse,” and
- if no breathing and a pulse, initiate rescue breathing and continue to check pulse; or
- if no breathing and no pulse, start CPR, followed by use of an AED “as soon as it is available.”<sup>5</sup>

## Prior OIG Reports

In an OIG report published in July 2021, the OIG substantiated that facility leaders did not conduct an [institutional disclosure](#) following awareness of a patient’s suicide, as required. The OIG made 10 recommendations, with one recommendation related to an issue addressed in this report regarding institutional disclosure. As of March 2022, all recommendations were closed.<sup>6</sup>

## Allegation and Related Concerns

The OIG received an inquiry from Senators Catherine Cortez Masto and Jacky Rosen in response to a media story that aired in May 2022, with video of an incident in late spring 2021 at the VA clinic in which a patient died following an alleged delay in staff providing intervention and care.<sup>7</sup> The OIG opened an inspection to review the care of the patient who fell in the clinic and subsequently died.

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<sup>4</sup> American Heart Association, “Basic Life Support (BLS),” accessed October 12, 2022, <https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/basic-life-support-bls-training>. American Heart Association, “Out-of-hospital Chain of Survival,” accessed October 12, 2022, <https://cpr.heart.org/en/resources/cpr-facts-and-stats/out-of-hospital-chain-of-survival>. The American Heart Association describes the chain of survival in an out-of-hospital patient setting to include activation of emergency response, early CPR, rapid defibrillation, advanced resuscitation, post-cardiac arrest care, and recovery.

<sup>5</sup> American Heart Association, *Basic Life Support-Provider Manual*, October 2020. Emmons J, Cooney DR. Scene Safety and Size-Up. In: Cooney DR. eds. *Cooney's EMS Medicine*. McGraw Hill; 2016, accessed September 30, 2022, <https://accessemergencymedicine.mhmedical.com/content.aspx?bookid=1650&sectionid=107954512>. Scene safety includes “sizing up” the scene of an incident to “ensure that there is a safe scene on which to provide care.”

<sup>6</sup> VA OIG, [Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas](#), Report No. 20-02993-181, July 15, 2021.

<sup>7</sup> In summer 2021, the OIG received an allegation regarding the VA clinic in which a nurse failed to assess a patient’s “condition in a timely manner resulting in a delay for CPR and the AED” but the OIG was unable to review the complaint due to an inability to identify the patient at the time.

During the inspection, the OIG identified concerns related to the quality of care provided to the patient in the days prior to and at the time of the incident. Additional concerns included leaders' response to the incident and staff knowledge of the processes in place for advance healthcare planning with patients.<sup>8</sup>

## Scope and Methodology

The OIG initiated the inspection on June 9, 2022; and conducted a virtual site visit July 6–August 4, 2022; an on-site visit August 8–9, 2022; and follow-up interviews through September 15, 2022. The inspection focused on care provided from early 2021–late spring 2022, as well as notes related to the patient's care at the clinic during 2018.<sup>9</sup>

The OIG interviewed the patient's roommate; relevant leaders and clinic staff; facility Quality, Safety, and Value (QSV) staff; facility nursing leaders; VA police; VISN and facility leaders; and other staff with knowledge of the incident or patient.

The OIG reviewed Veterans Health Administration (VHA) directives, handbooks, and memoranda; facility and clinic policies, procedures, and training records; incident reports, selected [peer reviews for quality management](#), Peer Review Committee documentation, the patient's electronic health record (EHR), and other documents relevant to the inspection. The OIG subpoenaed, received, and reviewed the patient's medical records from paramedics and a community hospital where the patient was treated after the incident.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–24. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations

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<sup>8</sup> The OIG uses the term 'incident' to identify the patient's fall and subsequent death in late spring 2021.

<sup>9</sup> Early 2021 was selected as this was when the patient last attended a primary care appointment before the episode of care on the day of the incident.

to VA leaders on patient care issues. Findings and recommendations do not define a [standard of care](#) or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Patient Case Summary

The patient was in their 80s with a medical history remarkable for obstructive [sleep apnea](#), high blood pressure, chronic kidney disease, [hyperlipidemia](#), severe [coronary artery disease](#), and heart failure who was followed by a specialist at the facility and primary care providers in the clinic.<sup>10</sup> In late spring 2018, the patient underwent a coronary [angiogram](#) and was diagnosed with severe three-vessel coronary artery disease and heart failure. The cardiologist recommended surgical therapy with a coronary artery bypass grafting procedure as well as optimization of the patient's cardiac medications. In late summer 2018, the patient attended a follow-up appointment with a physician primary care provider (PCP 1) to discuss the cardiac recommendations. During this visit, the patient declined heart surgery and declined medical therapy for hyperlipidemia. PCP 1 added a new medication for blood pressure control to the existing blood pressure control medication regimen. PCP 1 also recorded that the patient "doesn't want CPR" and advised that the patient "complete [[advance directive](#)]" to clarify wishes.

The next day, PCP 1 discontinued one of the patient's blood pressure control medications secondary to the patient's complaints of dizziness and started the patient on an alternative blood pressure control medication. The following week, the patient met with a social worker who provided information regarding the purpose of creating an advance directive. The patient submitted a completed advance directive several days later, which was sent for scanning into the patient's EHR. In the document, the patient appointed a roommate as a health care agent. PCP 1 did not enter a [life-sustaining treatment](#) plan or order into the EHR to formalize the patient's wish for no CPR.

The patient had regular primary care clinic appointments from 2018 through 2021 and continued to take two medications for blood pressure control. In a telehealth visit in early 2021, another primary care provider (PCP 2) recorded that the patient was "doing well. No recent episodes of dizziness or falls" and instructed the patient to continue blood pressure medications as prescribed.

In late spring 2021, the patient presented to the clinic for a nursing same-day access visit. The nurse who saw the patient recorded that the patient said the blood pressure control medication "is making [the patient] feel dizzy, patient states when [the patient] takes the medication it makes it

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<sup>10</sup> The OIG uses the singular form of they (their) in this instance for privacy purposes.

feel like the room is spinning.” The nurse advised the patient “to keep [the] appointment [four days later] and discuss [the] medication then.” The nurse did not record a set of vital signs at this visit. The nursing note was cosigned the same day by a newly assigned primary care provider (PCP 3).

The patient presented to the clinic for the scheduled follow-up appointment four days later. On intake, a licensed practical nurse noted that the patient was “winded when ambulating, has unsteady [gait](#) and needs walker for assistance.” The patient’s vital signs were remarkable for an elevated pulse of 105.<sup>11</sup> The licensed practical nurse recorded that the patient had fallen four times in the past year, most recently the previous month, but did not document a set of [orthostatic vital signs](#).

During the clinic visit with PCP 3, the patient relayed having symptoms of dizziness on and off for the prior four weeks and reported stopping one of the medications for blood pressure control with some improvement of the dizziness. The patient also complained of swelling in both feet. The patient’s roommate provided additional history to PCP 3 via telephone during this visit, stating that the patient had fallen at home about six times in the past month and had occasional difficulty with memory recently. PCP 3 reviewed blood work results from blood taken five days prior, which revealed a mildly elevated [potassium](#) level and mild worsening of chronic kidney disease. PCP 3 ordered a chest x-ray, repeat blood work to recheck the potassium and kidney function, and documented a plan to order imaging of the brain. PCP 3 also discontinued one blood pressure medication, reduced the dose of another, and referred the patient to the falls prevention clinic. The patient was scheduled for a primary care follow-up visit in three months and PCP 3 accompanied the patient to the clinic door leading to the lobby.

After the patient exited the treatment area, a clinic nurse practitioner documented “Responded to overhead page of “emergency” in the lobby. [Patient] found down on the lobby floor, unresponsive, pulseless. Per [registered nurse] report, 911 called; CPR initiated, AED placed. No shockable rhythm, CPR continued [Emergency Medical Services] arrived, continued CPR, transferred to [a non-VA facility].”<sup>12</sup> Later in the day, PCP 3 added an addendum to the EHR that stated the patient had been escorted to the clinic door after the visit and “ambulated with [a]

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<sup>11</sup> Mayo Clinic, “What’s a normal resting heart rate?” accessed October 6, 2022, <https://www.mayoclinic.org/healthy-lifestyle/fitness/expert-answers/heart-rate/faq-20057979#:~:text=A%20normal%20resting%20heart%20rate%20for%20adults%20ranges%20from%2060,to%2040%20beats%20per%20minute.> “A normal resting heart rate for adults ranges from 60 to 100 beats per minute.”

<sup>12</sup> Wanwan Zhang et al. “Conversion from Nonshockable to Shockable Rhythms and Out-of-Hospital Cardiac Arrest Outcomes by Initial Heart Rhythm and Rhythm Conversion Time,” *Cardiology Research and Practice*, March 27, 2020, accessed February 3, 2023, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7142338/>. Non-shockable or “No shockable rhythm” refers to an AED reading in which the patient would not benefit from defibrillation. During intervention, patients may convert from non-shockable to shockable.

walker without any difficulty.” PCP 3 documented “responding to an emergency call” in the lobby and found “the patient was [being] resuscitated by clinic staff and 911 crew.”

The following day, a facility community care nurse entered an EHR note that documented, “Patient reportedly suffered a loss of consciousness, fell, hit [their] head, and was found to be in cardiac arrest and [[pulseless electrical activity](#)] by arriving units of [Emergency Medical Services]. Patient was intubated on scene, [[Advanced Cardiac Life Support](#) (ACLS)] was started with multiple rounds of [epinephrine](#), was brought to the emergency department still in [pulseless electrical activity] and undergoing CPR.” The note also documented that after discussion with the family, resuscitative efforts were terminated, and the patient was pronounced dead.

## Inspection Results

### 1. Quality of Care Concerns

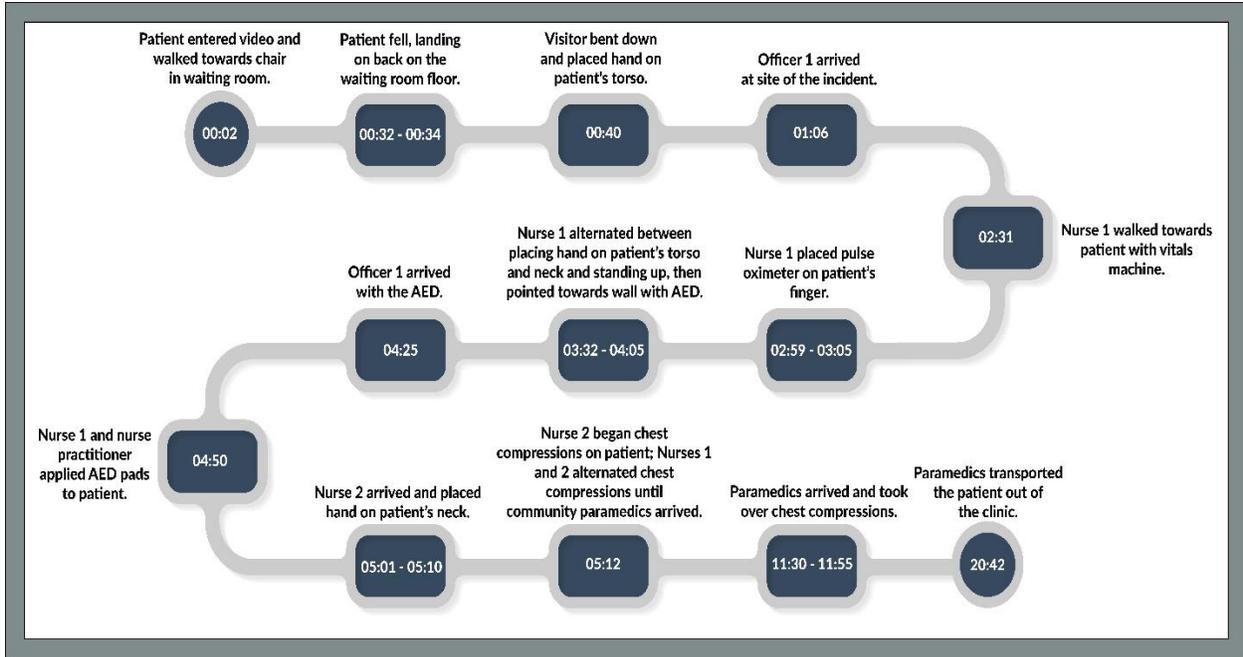
The OIG substantiated that staff’s initiation of CPR on the day of the patient’s death was delayed. The OIG determined that failures in response to the medical emergency included ineffective emergency notification speakers to activate the emergency response, and incomplete incident documentation and review. The OIG also found that PCP 3 evaluated the patient on the day of the incident but at the time did not further evaluate the cause of the patient’s dizziness and elevated heart rate. In addition, the OIG found that four days prior to the incident, a clinic nurse care manager did not evaluate the patient’s reports of dizziness.

#### Delayed Response to the Medical Emergency

The OIG reviewed the video of the patient’s fall and subsequent response by clinic staff and, using a combination of observations, interviews, the patient’s EHR, and review of facility documents, made determinations regarding the expediency of the care provided.

On video, a visitor and a VA police officer (Officer 1) initially responded to the patient, and approximately two and a half minutes after the patient fell, a nurse (Nurse 1) walked towards the patient with a portable vital signs machine (see figure 1). The patient was on the ground when Nurse 1 bent over and placed a [pulse oximeter](#) on the patient’s finger, stood up, and stepped back towards the vital signs machine. The nurse bent over again, placed a hand on the patient’s chest, and then moved the fingers towards the patient’s neck, such as to check for a pulse. Nurse 1 stood up, stepped back, pointed towards the wall where the AED was located, and Officer 1 returned with the AED roughly twenty seconds later. A nurse practitioner arrived and assisted with placing AED pads on the patient’s chest. Approximately two minutes after Nurse 1 responded, Nurse 2 arrived on the scene, felt for a pulse, and started CPR. Approximately four and a half minutes after the patient’s fall, CPR was started. Clinic staff continued CPR until

emergency medical services arrived and assumed care of the patient. The patient was transferred to a community hospital emergency room and was pronounced dead.



**Figure 1.** Time frame of Video of the Patient’s Incident in Late Spring 2021.

Source: The OIG reviewed the video without audio and verified the sequence of events through interviews.

Note: The OIG converted actual times noted on the video to approximated time in minutes and seconds (00:00) for evaluation of time lapsed from the time of the patient’s appearance on the video.

### Delayed Initiation of CPR

The OIG substantiated that a nurse delayed initiating CPR for the patient after establishing the patient did not have a pulse and was not breathing. However, the OIG was unable to determine if the delay in initiating CPR led to the patient’s death. The OIG was also unable to determine the exact time the patient ceased to have a pulse because it could not be validated on the video and there was no documentation for review.

The OIG determined that the first clinical staff to arrive, Nurse 1, evaluated the patient but did not initiate CPR once the patient’s pulse was not detected. For emergent events in VA facilities outside medical centers, clinical staff are required to call 911 for transfer to an appropriate care setting. If an individual is unresponsive, clinical staff are expected to initiate BLS, including retrieving the AED and initiating CPR.<sup>13</sup> Specifically, VHA policy states that “when a patient presents to a site of primary care delivery needing emergency medical care, [patient aligned care team (PACT)] staff must rapidly evaluate the patient and: (1) Access emergency responders. . . ;

<sup>13</sup> MCP 11-20-34, Management of Medical Emergencies at Off Site Medical Center Locations, September 2, 2020.

(2). . . administer [BLS], activate 9-1-1, or use an [AED] when clinically indicated. . . ” “PACT staff may not assume the responsibilities of emergency medicine providers when functioning in a primary care role.”<sup>14</sup>

Regarding optimal timing of CPR, the American Heart Association indicates that “CPR started immediately after cardiac arrest combined with early defibrillation” are the “actions most closely related to good resuscitation outcomes.”<sup>15</sup> Additionally, research has shown higher survival rates in adults who received CPR from a bystander or prehospital defibrillation.<sup>16</sup> The OIG consulted with VHA’s National Program Director for Pulmonary, Critical Care, and Sleep Medicine regarding processes for critical care incidents. According to the National Program Director, when managing an emergency response in a clinic, staff are expected to call 911 first, and initiate CPR as soon as possible to ensure the best outcome for a patient in cardiac arrest.

Nurse 1 reported being notified of a patient fall by instant messaging from a medical support assistant (MSA), and stated to the OIG, “it was not portrayed to me. . . as if it was an urgent situation.” During an interview, Nurse 1 told the OIG the pulse oximeter did not detect a pulse and the patient had a head injury, and reported noting the presence of the patient’s blood on the floor and saliva in the patient’s mouth. Nurse 1 described attempting to take the patient’s blood pressure but the patient’s tone was flaccid and body temperature was cool. In addition, Nurse 1 noted not having any gloves, continuing to motion for someone to bring the AED, and instructing staff to call an overhead page, call 911, bring oxygen, and get help. Nurse 1 described being concerned that doing chest compressions might have worsened the head injury but acknowledged to the OIG that upon reflection, CPR should have been started sooner.

The OIG determined that Officer 1 assisted in accessing the AED. Facility policy requires VA police to “respond to lifesaving emergencies with an AED” and to “perform basic life saving measures until qualified medical staff arrive.”<sup>17</sup> A facility leader reported, “police. . . if they’ve witnessed the emergent issues then they’re present, but they are not expected to provide any medical care although I know they are BLS certified.”

Officer 1, the first staff to arrive at the patient’s side, told the OIG that upon arrival at the scene, the patient was on the floor. Officer 1 reported inquiring if the patient was okay and if the patient had fallen and hit their head; the patient’s eyes were open and the patient “sort of nodded.” The

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<sup>14</sup> VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, amended May 26, 2017.

<sup>15</sup> American Heart Association.

<sup>16</sup> Comilla Sasson, MD, MS et.al. “Predictors of Survival From Out-of-Hospital Cardiac Arrest,” American Heart Association Circulation: Cardiovascular Quality and Outcomes, 2010, accessed November 14, 2022, [https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.109.889576?url\\_ver=Z39.88-2003&rft\\_id=ori:rid:crossref.org&rft\\_dat=cr\\_pub%20%20pubmed](https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.109.889576?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%20%20pubmed).

<sup>17</sup> MCM 11-18-14, Provision of Care, Treatment and Services, December 2018.

OIG determined that at the point in time when Officer 1 interacted with the patient, the patient was responsive and therefore, Officer 1 would not have been expected to initiate CPR.

The OIG determined that clinic staff who were required to have BLS training were BLS certified at the time of the incident in late spring 2021 and at the time of the on-site inspection in August 2022.<sup>18</sup> VHA requires BLS certification for all clinical staff prior to assuming clinical duties.<sup>19</sup> The OIG would expect trained staff to know and follow BLS steps, including more immediate assessment and response to the patient's changing condition.

The OIG concluded that the responding nurse, who was BLS certified, noted the lack of a pulse on the initial assessment but did not initiate CPR.

### *Ineffective Emergency Notification Speakers*

The OIG determined that the clinic's overhead speakers for activating the emergency response had not been working and there were difficulties with hearing the overhead speakers throughout the clinic before and at the time of the incident.

Facility policy requires clinic "staff who encounter an individual in acute distress" to contact a clinician who, if determined to be warranted, "will direct staff to call '911.'" "If the individual is unresponsive, clinical staff. . . will respond within their privileges, scope of practice and/or training." The first responder will "notify others in the vicinity for help" and "911 will be called immediately."<sup>20</sup> Additionally, VA Police are required to "announce emergency notifications via overhead speakers."<sup>21</sup>

In an interview with the OIG, an MSA, who was present during the incident but was initially unable to see the patient, said a female yelled that the patient fell. The MSA reported seeing Officer 1 near the patient, who was lying on the floor. The MSA told the OIG of running to the back of the clinic and walking into the nurses' station to alert Nurse 1 that the patient had fallen and hit their head. According to the MSA, Nurse 1 arrived on the scene and instructed the MSA to dial 911, which the MSA did after returning to the MSA's desk. Officer 1 reported calling a second VA police officer (Officer 2) by radio to request that the officer get the medical staff. Officer 1 told the OIG of noticing the MSA running across the lobby, other medical staff "just standing around," and a female waving Officer 1 to come over to the patient.

The MSA also told the OIG that the process for handling an emergency in the lobby at the time of the event was for one MSA to stay with the patient and another MSA to go to the back of the

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<sup>18</sup> VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021. VHA requires BLS certification for "all clinically credentialed and/or clinically privileged staff. . . including any employee involved in patient care" in an outpatient setting.

<sup>19</sup> VHA Directive 1177.

<sup>20</sup> MCP 11-20-34.

<sup>21</sup> MCM 11-18-14.

clinic to obtain assistance. The chief of primary care stated that a clinical team member usually requests a call be made to 911, but anyone in the clinic may call.

A patient safety coordinator told the OIG that the patient safety staff had been aware that the overhead speakers had not been working and, since the clinic is in a leased building, engineering staff were working with a site manager to have the repairs done. A former clinic nurse manager confirmed a history of difficulties with the overhead speaker system and stated the overhead speakers did not start working until March or April 2021, after the system was assessed and the problem was identified as electrical. The former clinic nurse manager noted that some staff had a portable phone system that could be used to communicate with one another but this was not accessible to everyone in the clinic. Nurse 2 reported being told that use of the overhead speaker system was discouraged prior to the incident and believed it was because the overhead speakers could not be heard in all parts of the clinic. In an interview with the OIG, the facility emergency manager reported that at the time of the incident, there were known problems with hearing the overhead speaker system in all areas of the clinic and the best way to make notification was by word of mouth. Two nursing staff, at the time of the incident, confirmed difficulty hearing the overhead speakers.

Since the incident, staff reported

- receiving training on emergency response,
- being re-educated on how to use the overhead speaker system,
- implementing a new process in which MSAs call for emergency response using the overhead speaker system and state the message three times to allow staff to come out of exam rooms to hear a message, and
- receiving guidance that anyone in the clinic can call 911.

While on-site in early August 2022, the OIG was present when an emergency occurred in the lobby and was announced on the overhead speakers. The OIG heard the announcement and observed staff appropriately responding with the AED and medical supplies. However, later in the day, the OIG was informed of another code that was announced overhead but not heard by OIG staff. In addition, OIG staff noted clinic areas where the overhead speakers were difficult to hear. The OIG concluded that while significant improvements have been made to emergency response processes, the notification for staff via overhead speakers is an important tool for immediate response by clinical staff that continues to have limitations.

### *Establishment of Scene Safety*

The OIG determined safety at the scene of the incident was established. One of the initial steps in BLS is to establish scene safety, which includes “siz[ing] up” the scene of an incident to “ensure there is a safe scene on which to provide care,” with the goal being “to protect patients from

unsafe conditions, but also to prevent responders and bystanders from becoming patients and requiring additional scene resources.”<sup>22</sup>

Staff reported concerns regarding the management of the visitors in the lobby. The video showed a female visitor providing comfort to the patient who was lying on the floor. Nurse 1 described asking a male bystander to move back after mistakenly believing the male bystander, who appeared to be comforting the patient, was family. Nurse 2 reported noting the male bystander video recording the incident and requesting a police officer to ask the male bystander to stop recording.

Officer 1 informed the OIG that when the clinic medical staff arrived on scene, there were 10–15 visitors, patients, and family members in the lobby, and they were able to secure the scene. In addition, Officer 1 reported medical staff were arriving to see what was occurring but were not engaged in the incident. Officer 1 reported instructing staff to return to their offices and to let on-site staff attend to the patient. Officer 2 directed visitors away from the incident and to their appointments.

The OIG concluded that police officers recognized that scene safety was required; however, they were unable to focus solely on addressing the management of the other visitors, patients, and family members in the area until additional staff arrived to care for the patient who fell. The facility conducted subsequent emergency response training and OIG staff observed effective emergency notification and the orderly and timely staff response to a later on-site emergency. VA police at the facility must continue to be properly trained on emergency responses, including securing the scene.

### *Incomplete CPR Documentation and Review*

The OIG determined that staff did not complete the proper documentation of the incident and that the incident was not reviewed by the CPR committee, as required. The OIG did not find evidence of a completed CPR record form for the patient’s incident. Documentation was limited to a progress note written by the nurse practitioner who responded to the incident and an EHR entry made by PCP 3.

VHA requires that “each resuscitative episode of care” is reviewed by the CPR committee.<sup>23</sup> “The CPR committee is an inter-professional committee providing oversight to proactive and retrospective activities to ensure that quality emergency response services are provided.” The review of documentation following a resuscitative episode of care with subsequent reporting to

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<sup>22</sup> Emmons J, Cooney DR. Scene Safety and Size-Up. In: Cooney DR. eds. *Cooney's EMS Medicine*. McGraw Hill; 2016, accessed September 30, 2022, <https://accessemergencymedicine.mhmedical.com/content.aspx?bookid=1650&sectionid=107954512>.

<sup>23</sup> VHA Directive 1177.

the Critical Care Committee is one of the ways this is accomplished.<sup>24</sup> The facility quality manager, with the CPR committee, is responsible for “addressing any delays in initiating CPR in house and problems in obtaining the assistance of [emergency medical services]. . . identified through the analysis of real code events.”<sup>25</sup>

Although the CPR committee was responsible for reviewing inpatient and outpatient events, the chair reported that the committee did not review the incident as there was no CPR form completed for submission to the committee. Facility policy requires that in the event of a cardiopulmonary incident, resuscitation will be documented on the CPR record form and processed with notification to the chair of the CPR committee and the intensive care unit nurse manager.<sup>26</sup> A clinical staff member at the scene is to document specific information regarding the patient and incident, the patient’s condition such as vital signs and cardiac rhythm, a sequence of events of any treatments provided, and the patient’s final disposition on the CPR form.<sup>27</sup>

Both nurses who responded to the incident told the OIG that they did not document anything after the patient’s incident. One nurse noted thinking someone else documented and the other nurse explained being “in shock.” The former nurse manager told the OIG of being unsure if the CPR record form was in use at the time of this patient incident. Another nurse manager interviewed by the OIG reported the belief that a checklist in use was considered a working document and was not scanned into the patient’s EHR, but that information such as vital signs might be entered into the EHR.

The OIG did not find evidence of a CPR record form in the patient’s EHR, and the CPR committee chair told the OIG of being unaware of the incident until the OIG inspection interview in summer 2022, more than a year after the incident. The OIG confirmed that the review of the incident by the CPR committee occurred shortly thereafter in summer 2022, and minutes show a recommended action to update the committee “charter to clarify that CPR committee reviews off-site resuscitation events.” The lack of an earlier review of the incident impacted the time frame in which the CPR committee and leaders were able to assess and provide targeted training for clinical processes, as needed.

## **Inadequate Patient Assessment and Management**

The OIG reviewed the care provided to the patient immediately preceding and four days prior to

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<sup>24</sup> VA Southern Nevada Healthcare System, *CPR Committee VA Southern Nevada Healthcare System 2020-2022*. CPR Committee reports include “the timeliness of initiation of resuscitation efforts and the appropriate use of skills, equipment, and medications.”

<sup>25</sup> VHA Directive 1177.

<sup>26</sup> MCP 11-20-34.

<sup>27</sup> MCP 11-20-34.

the incident and found these appointments presented potential opportunities for additional assessment of the patient's symptoms. PCP 3 evaluated the patient on the same day as the incident and was aware of a note entered by a clinic nurse care manager four days prior to the incident but did not further evaluate the cause of the patient's dizziness and elevated heart rate. The clinic nurse care manager who saw the patient four days prior to the incident did not take vital signs or refer the patient for a same-day assessment by a provider at that time.

### *Same-Day Visit*

The OIG found that PCP 3 evaluated the patient for the first time on the day of, but prior to, the incident. At that appointment, prior to PCP 3 seeing the patient, the licensed practical nurse documented the patient's vital signs including an elevated heart rate (pulse) of 105 beats per minutes, the patient's falls, and unsteady gait. Orthostatic vital signs were not documented. When asked by the OIG about this, the licensed practical nurse reported that a licensed practical nurse would not typically initiate orthostatic vital signs without direction to do so from a PCP.

After seeing the patient, PCP 3 documented a plan for orders for further blood work, chest x-ray, head imaging, and consults, including for evaluation of falls. In addition, PCP 3 adjusted the doses of the patient's existing blood pressure medications and requested a return appointment in three months. PCP 3 told the OIG of noting the elevated heart rate but felt it was not outside the range for this patient and acknowledged attributing it to the stress of the appointment. PCP 3 stated the patient did not have respiratory distress or chest pain during the appointment.

The OIG concluded that, given the patient's presentation, PCP 3 could have ordered additional tests to be completed at the time of the patient's evaluation, such as orthostatic vital signs or an [electrocardiogram](#). However, the OIG is unable to determine if ordering such additional tests would have changed the patient's clinical course.

### *Visit Four Days Prior*

The OIG found that the patient presented to the clinic four days before the incident with reported recent dizziness. However, a clinic nurse care manager who evaluated the patient did not take vital signs or refer the patient for a same-day assessment by a provider. Rather, the nurse care manager documented advising the patient to attend the scheduled PACT appointment in four days.

VHA requires that PCPs and registered nurses ensure same-day access to care, which "is the ability to schedule an appointment within one business day of when the patient contacts the facility." Specifically, primary care staff must "offer clinically indicated care to the patient that is respectful of the patient's preferences and appropriate for the safe delivery of care." In addition, VHA directs that "care coordination processes must ensure: (a) There is no lapse in care for the

patient [and] (b) Relevant information is communicated to involved providers.” PACT registered nurses “determine care management requirements for individual patients.”<sup>28</sup>

The OIG found that the nurse care manager documented the patient’s complaint of recent dizziness caused by medication. The nurse care manager reported to the OIG documenting a patient’s visit as a “non-symptom request” when the patient was “not actively having symptoms” and not “acutely in distress.”<sup>29</sup> The nurse care manager also reported advising the patient to take medication as ordered and return for the scheduled appointment, and that the provider was alerted to this contact by being added as an additional signer to the note. Documentation showed that PCP 3 acknowledged the nurse care manager’s note several hours later the same day.

In an interview with the OIG, the Associate Director of Patient Care Services said that after reviewing the patient’s EHR and given the patient’s complaint of dizziness, the nurse care manager would have been expected to do “a more thorough assessment,” such as taking orthostatic vital signs or referring the patient to a provider that day. The chief of primary care also reported being surprised that the nurse care manager did not take vital signs when the patient reported recent dizziness.

The chief of primary care told the OIG of understanding that nurses follow triage guidelines for same-day access patients. The OIG reviewed the nursing protocol and EHR templates for non-symptom and symptom triage and determined that if the nurse care manager had determined the visit to be a “symptom request” for dizziness, the accompanying template would have required a plan, which may have included a referral to a provider.

The OIG concluded that an assessment of the patient’s reports of dizziness was warranted but not completed, resulting in the lack of an adequate plan to address the patient’s symptoms of dizziness. The OIG would have expected the nurse care manager to evaluate the patient’s reported dizziness symptoms by taking the patient’s vital signs, consulting with a physician, or referring the patient to be assessed by a provider that day. During the inspection, the OIG found that the nurse care manager’s assessment of the patient was reviewed and discussed with the nurse care manager. Therefore, the OIG did not make a recommendation.

## 2. Facility Leaders’ Response to the Incident

The OIG determined that facility leaders’ reviews of the incident were limited by the lack of information documented in the EHR, and that decisions were made based upon an unconfirmed determination of the patient’s cause of death. The OIG found that in response to the incident,

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<sup>28</sup> VHA Handbook 1101.10(1).

<sup>29</sup> Facility staff provided the EHR note template and documentation that verified non-symptom requests are “for assistance that do not require assessment of physical symptom [and] complaints but rather needs a task by PACT team completed.” Whereas symptom requests are “when the patient presents with a symptom [and] physical complaints.”

facility leaders conducted an emergency management debrief and promptly completed an after-action review that resulted in staff education. The OIG determined that leaders' scoring of the incident was based on the unconfirmed determination of the patient's cause of death and did not trigger required patient safety reviews and disclosure. Additionally, the OIG determined that a lack of documentation related to the medical care provided at the time of the incident contributed to incomplete reviews by facility leaders of the clinical care provided to the patient and the inability to adequately review the actions taken by clinicians at the scene.

## **Emergency Management Review**

The OIG found the Facility Director initiated and the emergency preparedness manager completed an emergency management after-action review of the emergency response to the patient's death, resulting in additional incident command and BLS education provided to clinic staff, as required.

The facility emergency operations plan is designed to help staff "effectively respond and recover from an internal or external emergency that may impact any VASNHS [VA Southern Nevada Health Care System]" facility. The plan states that an after-action report should be completed following an emergency and shall describe "the problems identified during the drill or event, corrective actions to be taken, and staff participation."<sup>30</sup>

The emergency preparedness manager reported the after-action debrief was conducted two days after the incident and the staff documented as participating included primary care, nursing, business administration services, police, patient safety, social work, and site leaders. Participants discussed what occurred and potential improvements.

Attendance records reviewed by the OIG show that education regarding incident command, the medical emergency response process, BLS, and the facility's hazardous vulnerability analysis summary was provided to clinic staff two weeks after the patient's death, and that other facility primary care clinics received the same training within three months after the patient's death. In addition, clinic staff reported, and the OIG observed, that a daily schedule was now in use to document the roles of specific staff members when emergencies occur within the clinic to include the persons responsible for bringing the AED and emergency bag, and assignment as the rapid response leader. Furthermore, the emergency preparedness manager reported additional drills were initiated that will focus on clinic staffs' response to an unplanned enactment of a person's medical emergency.

Staff reported in interviews that the training helped improve the emergency preparedness and response and one nurse stated, "I feel like they did immediately try to improve our rapid response." During the on-site inspection, the OIG witnessed clinic staff's actual rapid response to

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<sup>30</sup> VA Southern Nevada Healthcare System Emergency Operations Plan, December 2020.

a patient's medical emergency in the lobby. OIG team members observed clinic staff members responding quickly in assigned roles and with emergency equipment, indicating that process changes and training have been effective.

The OIG concluded that corrective actions developed through the after-action debrief conducted by the emergency preparedness manager were sufficient to address the identified deficiencies. Education provided to clinic staff regarding emergency response, including command and control and CPR, has been effective in changing processes. However, monitoring is needed to ensure ongoing compliance and sustainability of the processes.

### **Modification of Incident Scoring**

The OIG found that facility and patient safety staff utilized the patient safety reporting system to review the incident.<sup>31</sup> However, the OIG found that staff originally gave the incident a higher safety assessment code (SAC) score that would trigger further review and later QSV leaders lowered the incident's SAC score to a level that did not require further action.

VHA's patient safety program focuses on "exploring system vulnerabilities that can result in patient harm." Reporting adverse events and close calls provides valuable opportunities to identify root causes and contributing factors, and develop actions "to mitigate future events from reoccurring within [the] facility."<sup>32</sup> VHA requires that once aware, facility staff must inform patient safety managers of any patient safety event, even if the condition has not resulted in an adverse event, close call, or unsafe condition.<sup>33</sup> The patient safety reporting system may be used to report the event.<sup>34</sup>

When staff enter an incident into the patient safety reporting system, "the first step taken by the [patient safety manager] after any required immediate action is to assign actual and potential [safety assessment code] score that then defines what further actions are necessary."<sup>35</sup> SAC

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<sup>31</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Program*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding patient safety reporting and root cause analysis as the 2011 handbook. VHA National Center for Patient Safety, *2020 JPSR Business Rules and Guidebook*, July 2020. This guidebook was in place during the time of the events discussed in this report. It was rescinded and replaced by *VHA Guidebook for JPSR Business Rules and Guidance*, November 2021. The two guidebooks have the same or similar language related to the classification of deaths related to SAC scoring. VHA uses a patient safety event reporting system and database called the Joint Patient Safety Reporting (JPSR) System. The patient safety reporting system is a user-based system where staff enter information related to unsafe conditions, adverse events, and close calls.

<sup>32</sup> VHA Handbook 1050.01.

<sup>33</sup> Within the context of this report, the OIG considered an adverse event to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher-level of care. VHA Handbook 1050.01.

<sup>34</sup> NCPS, 2020 JPSR Business Rules and Guidebook.

<sup>35</sup> VHA Handbook 1050.01.

scores are based upon severity of an incident and the probability of it happening again. Death “not related to the natural course of the patient’s illness or underlying condition” is classified as catastrophic and requires a [root cause analysis](#) or inclusion in an aggregated review.<sup>36</sup> VHA instructs patient safety managers to ensure that the severity in establishing the SAC score matches the degree of harm that occurred.<sup>37</sup> “The SAC score is not to be determined by any staff other than the [patient safety manager] or acting [patient safety manager].”<sup>38</sup>

The patient had a witnessed fall in the clinic waiting room and, at some undetermined time, went into cardiac arrest. The patient’s community hospital records documented “Cardiac arrest, at the VA” and that the patient presented to the community hospital emergency department “in cardiac arrest. [Patient] walked into the VA clinic and had a syncopal episode, hitting the back of [the patient’s] head.” The OIG’s review of the patient’s EHR and community hospital records, as well as the video recording of the incident, did not identify definitive evidence of the cause of the patient’s fall, or timing of the cardiac arrest or death. An autopsy was not performed to determine cause of death.

The facility patient safety manager originally scored the incident to require a root cause analysis.<sup>39</sup> However, during an interview with the OIG, the facility patient safety manager said the patient’s medical condition contributed to the fall and, therefore, did not require a root cause analysis. The patient safety manager reported consulting with the chief of QSV and jointly determining that “the patient suffered a cardiac arrest, collapsed, and then died as a result of the cardiac arrest, so we as a facility decided not to do a [root cause analysis] but instead to get emergency management involved.” The patient safety manager and chief of QSV each reported that this decision was based on the content in the patient’s community care emergency room note indicating the patient’s diagnosis of “cardiac arrest.”

Two facility leaders told the OIG that the SAC scoring for this incident was discussed with the VISN patient safety officer. The VISN patient safety officer provided documentation that showed the VISN patient safety officer decreased the SAC score three business days after the original score was entered. By updating the SAC score to a lower category, a root cause analysis was no longer required.<sup>40</sup> The VISN patient safety officer did not recall updating the SAC score

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<sup>36</sup> VHA Handbook 1050.01. Root cause analysis “is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events.” Aggregated reviews must be conducted every fiscal year for three areas: falls, missing patients, and adverse drug events.

<sup>37</sup> NCPS, 2020 JPSR Business Rules and Guidebook.

<sup>38</sup> VHA Handbook 1050.01. NCPS, 2020 JPSR Business Rules and Guidebook. Prior to assigning the final SAC score, the patient safety manager reviews the information provided by subject matter experts assigned to investigate the event. In this case, the patient safety manager consulted a primary care nursing leader, chief of primary care, facility safety and occupational health staff, and business administration staff.

<sup>39</sup> VHA Handbook 1050.01.

<sup>40</sup> VHA Handbook 1050.01.

within the patient safety report system, but when asked by the OIG about the change, reported that it was the result of a discussion with the facility patient safety manager. While the patient safety manager determines the SAC score, the patient safety reporting system allows access for specific users to change SAC scores.

The OIG heard concerns from staff that the incident was reviewed as an emergency management response instead of a patient safety event. The Facility Director told the OIG that internal reviews determined that the standard of care was met in this case, that “It was more the responsiveness that was of the most concern,” and that the due diligence of the after-action team was the predominant driver of resulting actions. A facility leader and supervisor reported that the emergency management debrief and review of the patient’s death sufficiently addressed any issues.

The OIG concluded that reliance on an unconfirmed determination of the patient’s cause of death impacted the SAC score given. As a result, a root cause analysis was not performed, which prevented assessment of other potential factors contributing to the incident, and staff response. Rather, facility leaders relied on an emergency management response tool not focused on clinical emergency procedures or patient safety to address the incident. Although the OIG finds a root cause analysis and emergency management review are not mutually exclusive, the OIG did not make a recommendation as corrective actions addressing clinic process gaps were completed based on the emergency management review.

### **Lack of Institutional Disclosure**

The OIG determined that due to the seriousness of the incident and unconfirmed cause of death, an institutional disclosure related to the delay in the provision of emergency care was warranted but did not occur.<sup>41</sup> VHA requires institutional disclosure be performed when the adverse event results in death, “including cases where the harm may not be obvious.”<sup>42</sup>

The intent of institutional disclosure is to fully inform patients and families about all clinically significant facts related to harm caused by VA medical care and options to pursue potential compensation.<sup>43</sup> VHA policy states that when it “may be apparent that an adverse event has occurred, but its cause is not clear. . . the Veteran or the Veteran’s personal representative needs to be told what has occurred and what is known about the problem. They need to be informed as to whether the problem is being investigated and if additional information will be provided to them once a review is completed.”<sup>44</sup>

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<sup>41</sup> VHA Directive 1004.08. *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>42</sup> VHA Directive 1004.08.

<sup>43</sup> VHA Directive 1004.08.

<sup>44</sup> VHA Directive 1004.08.

The OIG reviewed the patient’s EHR and did not find evidence of an institutional disclosure related to the incident. The Chief of Staff told the OIG this incident did not “meet criteria for the VA institutional disclosure guidelines” due to content in the patient’s EHR indicating “a physiological event (cardiac event leading to fall and injury).” The Chief of Staff reported that while viewing the video, there was a lack of certainty as to when the patient became pulseless and CPR should have been initiated, but response could have been better. The chief of QSV told the OIG “there was not an [institutional disclosure] discussion on this patient since the patient had a natural physiologic event related to [their] underlying condition that could not have been predicted.”

The OIG concluded that the incident ending with the patient’s death occurred at the clinic and based on the severity of the incident and the delayed initiation of CPR, a discussion with the patient’s next of kin or designated significant other regarding the potential causes of the delay and actions taken to prevent a similar occurrence was required.

### **Limited Peer Review**

The OIG found that the peer reviews conducted following the incident were limited by a lack of documentation in the EHR, and the inability of the reviewers to access the video.

VHA defines peer review for quality management as “a critical review of care performed by a peer” to include “identification of learning opportunities for practice improvement and any related improvement actions recommended.”<sup>45</sup> The primary focus of peer review is to determine whether the “clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care.”<sup>46</sup>

The OIG confirmed that two peer reviews were completed addressing the care provided during the same-day access appointment four days prior to the incident, and the primary care visit on the same day as, but prior to, the incident. The chief of QSV reported that a peer review was not completed on any staff who performed life-sustaining treatment on the patient because peer reviews are based on a review of the EHR and peer reviewers are unable to access videos. Additionally, the chief of QSV reported that the emergency medical response to the incident “was considered to be more of a process issue, not a peer review issue.” This explanation and rationale were echoed by the VISN patient safety officer.

The facility’s peer reviews specific to the incident were limited by a lack of documentation for review in the EHR and staff’s claims that the reviewers were unable to access the video. Although the OIG does not find that in every instance a lack of documentation precludes a peer review, in this instance, the facility addressed the CPR process issues with nursing staff through

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<sup>45</sup> VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

<sup>46</sup> VHA Directive 1190.

education and, therefore, the OIG did not make a recommendation. The OIG concluded the lack of documentation limited the review of the emergency clinical care provided and the ability to make recommendations to providers to improve future instances of emergency care.

## **Leaders' Review of Incident**

The OIG found that the Chief of Staff, Associate Director Patient Care Services, and chief of QSV each independently reviewed the incident in the patient's EHR; however, the leaders' reviews were limited due to lack of documentation of clinical care provided during the incident, including CPR efforts.

Facility policy states that the Chief of Staff and Associate Director Patient Care Services are responsible for "monitoring the quality and safety of clinical medical practice" and clinical nursing practice, respectively, within the facility.<sup>47</sup> The chief of QSV serves as a consultant to medical center leadership for quality and patient safety.<sup>48</sup>

The Facility Director told the OIG of advising the Chief of Staff, Associate Director Patient Care Services, and chief of QSV to conduct a review of the incident to determine actions warranted such as peer review and issue brief.<sup>49</sup> The Chief of Staff and the Associate Director Patient Care Services reported in interviews that their reviews included the EHR and police officers' report.<sup>50</sup> The Chief of Staff reported concerns regarding the lack of documentation of the incident in the EHR and that there "are parts I think could have been better addressed." During an interview, the Associate Director Patient Care Services reviewed the patient's record and noted concerns with the same-day access appointment nursing assessment prior to the incident and the responsiveness of nursing staff during the patient's incident. Both the Chief of Staff and Associate Director Patient Care Services reported concerns to the OIG regarding the video showing staff's lack of response and attention to the patient, noting the expectation was for staff to move to the patient's level and sit with the patient.

The chief of QSV told the OIG that a review included viewing the video of the incident, the patient's EHR, and patient safety report. The chief of QSV reported concern to the OIG related to documentation of the CPR provided and stated, "I think we could have done better with documenting the actual code event. I found that lacking." The chief of QSV indicated that the

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<sup>47</sup> Medical Center Memorandum 00-19-35, Organizational Framework for Quality, Safety, and Value, June 2019.

<sup>48</sup> MCM 00-19-35.

<sup>49</sup> Deputy Secretary for Health for Operations and Management (10N) Guide to VHA Issue Briefs, March 29, 2018. "Issue Briefs are drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue. Issue Briefs are designed to provide clear, concise, and factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care."

<sup>50</sup> The Chief of Staff indicated the review was completed after the incident was released by the media in 2022.

CPR committee reviewed the incident over one year after the patient’s death because the committee was unaware it had occurred due to lack of documentation on the CPR record form.

The OIG found that facility leaders completed limited reviews of the incident at the instruction of the Facility Director and, as a result, these reviews did not trigger, nor were they part of, any formal quality management review processes that may have improved documentation of the incident.

### **3. Staffs’ Understanding of Advance Care Planning Processes**

During the inspection, the OIG identified a deficiency in staffs’ understanding of advance care planning policies and procedures.<sup>51</sup>

VHA promotes a “proactive, patient-centered approach to decisions about life-sustaining treatments.”<sup>52</sup> VHA policy requires clinical staff to attempt CPR on every patient who sustains cardiopulmonary arrest unless specific criteria are met, including a documented order to not resuscitate or the patient having given unequivocal instructions to not perform CPR.<sup>53</sup> VHA policy does not explicitly require outpatient staff to review a patient’s life-sustaining treatment status prior to or during an emergency medical incident and, therefore, would not have impacted the decision to initiate CPR in this incident.<sup>54</sup>

Patients can make advance care planning preferences known by completing an advance directive or by a provider completing a life-sustaining treatment plan.<sup>55</sup> Facility leaders are responsible for ensuring appropriate staff are educated regarding advance healthcare planning.<sup>56</sup>

During interviews, leaders’ and staffs’ responses to questions regarding life-sustaining treatment orders and advance directives indicated a lack of understanding of advance care planning policies and procedures. For example, when asked about responsibility for completing advance directives, a primary care nurse leader replied “I don’t know for certain if the social worker can

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<sup>51</sup> For this report, the OIG considers advance care planning to include discussions and documentation about patients’ values, goals, and preferences, including advance directives and life-sustaining treatment decisions.

<sup>52</sup> VHA Handbook 1004.03(2), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences*, January 11, 2017, amended May 10, 2021. The handbook was in effect during the time of the events discussed in this report and was amended September 28, 2022.

<sup>53</sup> VHA Handbook 1004.03(2). VHA Handbook 1101.10(1).

<sup>54</sup> VHA Handbook 1004.03(2).

<sup>55</sup> VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013. “An advance directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions.” VHA Handbook 1004.03(2). Life-sustaining treatment plans are specific progress notes, order sets, and documents within a patient’s EHR that detail conversations between providers, patients, and if necessary, a surrogate about initiation of, limits of, or discontinuation of life-sustaining treatments such as artificial nutrition and hydration, mechanical ventilation, and CPR.

<sup>56</sup> VHA Handbook 1004.03(2). VHA Handbook 1004.02.

sign off or if it has to be the provider. I don't know.” Another staff reported being unsure of whether an advance directive was separate from a life-sustaining treatment order. The staff member responsible for compiling data related to life-sustaining treatment orders was unaware of the purpose of compiling the data or any resulting actions taken from the data.

While staffs' lack of understanding of advance care planning policies and procedures may not have resulted in a different outcome for this patient, the OIG identified this incident as an opportunity for facility and primary care leaders to assess staff knowledge of the advance care planning process, advance directives, and life-sustaining treatment decision processes, identify gaps, and develop actions accordingly.

## Conclusion

The OIG substantiated that a nurse delayed initiating CPR but was unable to determine if the delay led to the patient's death. While the exact time the patient ceased to have a pulse could not be validated on the video and there was no documentation for review, it is clear that the responding nurse noted a lack of pulse on the initial assessment but did not initiate CPR.

The OIG determined that, at the time of the incident, use of the overhead speakers for activating the emergency response was an ineffective method of communication because the overhead speakers were difficult to hear. The OIG concluded that while significant improvements have been made to emergency response processes, the notification for staff via overhead speakers is an important tool for immediate response by clinical staff that continues to have limitations.

The OIG concluded that police officers recognized that scene safety was required; however, they were unable to focus solely on addressing the management of the other visitors, patients, and family members in the area until additional staff arrived to care for the patient who fell. The facility conducted subsequent emergency response training and OIG staff observed effective emergency notification and the orderly and timely staff response to a later on-site emergency. VA police at the facility must continue to be properly trained on emergency responses, including securing the scene.

The OIG determined that staff did not complete the proper documentation of the incident and that the incident was not reviewed by the CPR committee, as required.

The OIG identified opportunities for improved clinical care immediately preceding and four days prior to the incident. On the day of the incident, the OIG found that, given the patient's presentation, additional tests such as orthostatic vital signs or an electrocardiogram could have been ordered by PCP 3. However, the OIG is unable to determine if ordering such additional tests would have changed the patient's clinical course. The OIG identified a missed opportunity to assess the patient's reports of dizziness when the patient presented to the clinic four days prior to the incident. This gap in care resulted in the lack of an adequate plan to address the patient's symptoms of dizziness.

The OIG found that in response to the incident, facility leaders conducted an emergency management debrief and promptly completed an after-action review that resulted in staff education. The OIG determined that leaders' scoring of the incident was based on the unconfirmed determination of the patient's cause of death and did not trigger required patient safety reviews and disclosure. Additionally, the OIG determined that a lack of documentation related to the medical care provided at the time of the incident contributed to incomplete reviews by facility leaders of the clinical care provided to the patient and the inability to adequately review the actions taken by clinicians at the scene.

During the inspection, the OIG found deficiencies in staffs' understanding of advance care planning policies and procedures, and identified this incident as an opportunity for facility and primary care leaders to assess staff knowledge of the advance care planning process, advance directives, and life-sustaining treatment decision processes, identify gaps, and develop actions accordingly.

## **Recommendations 1–5**

1. The VA Southern Nevada Healthcare System Director reviews processes in place to ensure proper response to future medical emergencies in outpatient clinics to include staff training, emergency notification systems, and emergency documentation processes.
2. The VA Southern Nevada Healthcare System Director reviews the process for and compliance with documentation of cardiopulmonary resuscitation in outpatient clinic settings, and takes action as indicated.
3. The VA Southern Nevada Healthcare System Director works with outpatient clinic leaders to ensure that all deficiencies identified in the after-action plan are completed and that compliance is monitored.
4. The VA Southern Nevada Healthcare System Director consults with Office of General Counsel's Regional Counsel to review the incident and determine if an institutional disclosure is warranted and takes action accordingly.
5. The VA Southern Nevada Healthcare System Director completes an evaluation of staffs' understanding of advance care planning, advance directives, and life-sustaining treatment decision processes, and takes action to address identified gaps.

## Appendix A: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 11, 2023

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System, Las Vegas, Nevada

To: Director, Office of Healthcare Inspections (54HL05)  
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We deeply regret the circumstances that impacted the care delivered to one of our Veterans. I have reviewed the draft report Healthcare Inspection—Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System, Las Vegas, Nevada.
2. The VA Southern Nevada Healthcare System (VASNHS) is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and the action plan of the VA Southern Nevada Health Care System in Las Vegas.
3. I would like to thank the Office of Inspector General for their thorough review of this case and if you have any additional questions, please contact the VISN 21 Quality Management Officer (QMO).

*(Original signed by:)*

Eileen V. Redmond  
Acting Network Director  
for

Ada Clark, FACHE, MPH  
Interim Network Director  
VA Sierra Pacific Network (VISN 21)

## Appendix B: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 5, 2023

From: Director, VA Southern Nevada Healthcare System (593/00)

Subj: Healthcare Inspection—Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System, Las Vegas, Nevada

To: Director, Sierra Pacific Network (10N21)

1. We are deeply saddened by the loss of this patient. Since 2021 when this event occurred, we have made substantial improvements to emergency responsiveness in our free-standing community clinics. This has resulted in strong practice improvements with coordination and promptness to emergency situations. We are pleased OIG acknowledged our improvements in the draft report and that they had an opportunity to witness, in person, an orderly and timely emergency response by staff during its visit.
2. VASNHCS aims to ensure all Veterans receive safe, quality care when they come through our doors. We are proud of the on-site police officer who was able to talk with the patient immediately after the event and fall. We are thankful that two nurses were on scene within minutes to evaluate the patient clinically and start lifesaving measures once the patient was no longer responsive. We agree with the OIG that the exact time the patient's pulse stopped could not be clearly determined, which means we cannot determine exactly when CPR should have started.
3. We value the hard-earned trust of Veterans who get their care at VASNHCS and community clinics. We are honored and privileged to serve over 75,000 Veterans in our catchment area every day. We have learned a great deal from this tragedy, have improved our processes, and aim to provide continued high-quality care to Veterans.
4. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues. We will take actions as recommended by the OIG to strengthen the care we provide.

*(Original signed by:)*

William J. Caron, PT, MHA, FACHE  
Medical Center Director/CEO  
VA Southern Nevada Healthcare System

## Facility Director Response

### Recommendation 1

The VA Southern Nevada Healthcare System Director reviews processes in place to ensure proper response to future medical emergencies in outpatient clinics to include staff training, emergency notification systems, and emergency documentation processes.

Concur.

Target date for completion: November 2021

### OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### Director Comments

The VA Southern Nevada Healthcare System Director reviewed processes in place to ensure proper response to future medical emergencies in outpatient clinics to include staff training, emergency notification systems, and emergency documentation processes. Facility leaders conducted an after-action review two days after the event. Participants included primary care service, including providers, nursing, mental health, business administration services, police, patient safety, social work, and site leaders. Participants discussed what occurred and potential improvements and developed an action plan report/improvement plan. Because the patient initially had a pulse, initiation of chest compressions was not indicated. Per American Heart Association 2020 Basic Life Support (BLS) Guidelines, cardiopulmonary resuscitation (CPR) is a lifesaving procedure and used for victims who show signs of cardiac arrest, which includes absence of a pulse. Once it was determined the patient did not have a pulse, CPR was initiated.

Staff were re-educated. Staff education for primary care service staff included information on incident command, the medical emergency response process, BLS/CPR (Go-Training), and the facility's hazardous vulnerability analysis summary which was provided to clinic staff. A daily schedule is now in use to document the roles of specific staff members when emergencies occur within the clinic to include the persons responsible for bringing the Automated External Defibrillator (AED), manual resuscitator, red emergency bag, scribe, glucometer, oxygen, a runner and assignment of the rapid response leader.

### Recommendation 2

The VA Southern Nevada Healthcare System Director reviews the process for and compliance with documentation of cardiopulmonary resuscitation in outpatient clinic settings, and takes action as indicated.

Concur.

Target date for completion: November 2021

### **OIG Comments**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### **Director Comments**

The VA Southern Nevada Healthcare System Director reviewed the process for and compliance with documentation of cardiopulmonary resuscitation in outpatient clinic settings. Facility leaders reviewed documentation requirements when cardiopulmonary resuscitation is performed with primary care staff during the above education previously provided. Additionally, nurse leaders verified that the CPR record is available for documentation purposes in the red emergency bags located at each clinic. Per Medical Center Policy 11-34, Management of Medical Emergencies at Off-Site Medical Center locations, CPR records are sent to the CPR Committee and Intensive Care Unit (ICU) nurse Manager for further review and evaluation. Any deficiencies identified during these reviews are forwarded to Primary Care leadership for follow-up action/s.

### **Recommendation 3**

The VA Southern Nevada Healthcare System Director works with outpatient clinic leaders to ensure that all deficiencies identified in the after-action plan are completed and that compliance is monitored.

Concur.

Target date for completion: November 2023

### **Director Comments**

The VA Southern Nevada Healthcare System Director worked with outpatient clinic leaders to ensure that all deficiencies identified in the after-action plan were completed and that compliance is monitored. All of the actions identified in the after-action plan were completed by November 23, 2021. In order to ensure continued compliance, BLS/CPR (Go-Training) is scheduled to be performed at all primary care clinics in 2023, commencing in May 2023.

Also, an Emergency Management liaison has been assigned to perform emergency management drills which will include the medical response at all of the Primary Care Clinics commencing no later than June 2023.

Code exercises and other emergency exercises will continue to occur at minimum annually at all primary care clinics.

#### **Recommendation 4**

The VA Southern Nevada Healthcare System Director consults with Office of General Counsel's Regional Counsel to review the incident and determine if an institutional disclosure is warranted and takes action accordingly.

Concur.

Target date for completion: June 2023

#### **Director Comments**

The VA Southern Nevada Healthcare System Director has consulted with the Office of General Counsel, District Chief Counsel Office. The incident was reviewed, and the facility is taking action, as advised.

#### **Recommendation 5**

The VA Southern Nevada Healthcare System Director completes an evaluation of staffs' understanding of advance care planning, advance directives, and life-sustaining treatment decision processes, and takes action to address identified gaps.

Concur.

Target date for completion: July 2023

#### **Director Comments**

The VA Southern Nevada Healthcare System Director will complete an evaluation of staffs' understanding of advance care planning, advance directives, and life-sustaining treatment decision processes, through administering an anonymous knowledge assessment to primary care service, including providers, nursing, mental health, business administration services, police and social work and will provide education to address any identified gaps.

## Glossary

*To go back, press “alt” and “left arrow” keys.*

**advanced cardiac life support.** Advanced lifesaving techniques for people with medical knowledge, including medications and intubation.<sup>1</sup>

**advance directive.** “[A] written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions.”<sup>2</sup>

**angiogram.** “An angiogram is a diagnostic procedure that uses X-ray images to look for blockages in your blood vessels (arteries or veins).”<sup>3</sup>

**automated external defibrillator.** “A portable electronic device that attaches to the chest and operates automatically to measure the heart’s rhythm to determine if an electric shock is needed. It is designed to be used by someone without medical training.”<sup>4</sup>

**cardiac arrest.** A “temporary or permanent cessation of the heartbeat.”<sup>5</sup>

**cardiopulmonary resuscitation.** “An organized, sequential response to cardiac arrest including recognition of absent breathing and circulation, basic life support with chest compressions and rescue breathing, advanced cardiac life support (ACLS) with definitive airway and rhythm control, post-resuscitative care.”<sup>6</sup>

**coronary artery disease.** Also known as coronary heart disease. A condition “that reduces blood flow through the coronary arteries to the heart and typically results in chest pain or heart damage.”<sup>7</sup>

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<sup>1</sup> National CPR Association, “What’s the difference between ACLS and BLS?” accessed September 29, 2022, <https://www.nationalcprassociation.com/whats-the-difference-between-acls-and-bls>.

<sup>2</sup> VHA Handbook 1004.02.

<sup>3</sup> Cleveland Clinic, “angiogram,” accessed January 3, 2023, <https://my.clevelandclinic.org/health/treatments/4977-angiography>.

<sup>4</sup> Merriam-Webster.com Dictionary, “automated external defibrillator,” accessed June 22, 2022, <https://www.merriam-webster.com/dictionary/AED>.

<sup>5</sup> Merriam-Webster.com Dictionary, “cardiac arrest,” accessed September 13, 2022, <https://www.merriam-webster.com/dictionary/cardiac%20arrest>.

<sup>6</sup> Merck Manual, “Cardiopulmonary Resuscitation (CPR) in Adults,” accessed September 28, 2022, <https://www.merckmanuals.com/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiopulmonary-resuscitation-cpr-in-adults?query=cpr#v925728>.

<sup>7</sup> Merriam-Webster.com Dictionary, “coronary heart disease,” accessed September 16, 2022, <https://www.merriam-webster.com/dictionary/coronary%20disease>.

**electrocardiogram.** “An electrocardiogram [or EKG] records the electrical signals in the heart.”<sup>8</sup>

**epinephrine.** A “blood-pressure raising hormone” that is used “to stimulate the heart during cardiac arrest.”<sup>9</sup>

**gait.** “A manner of walking or moving on foot.”<sup>10</sup>

**hyperlipidemia.** A condition in which cholesterol and triglycerides (or a combination of both) are abnormally elevated in the blood.<sup>11</sup>

**institutional disclosure.** A formal process in which facility leaders and clinicians inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and provide information about rights and recourse.<sup>12</sup>

**life-sustaining treatment.** “A medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment.”<sup>13</sup>

**orthostatic vital signs.** “Orthostatic vital signs are performed with the patient in different positions. . . This procedure is used for noninvasive evaluation of fluid loss. . . to evaluate cerebral hypotension. . . weakness or dizziness. . . and response to a change in position in the older adult.”<sup>14</sup>

**peer reviews for quality management.** A critical review of care to determine “whether the clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care.”<sup>15</sup>

**potassium.** “an essential nutrient that is naturally present in many foods and available as a dietary supplement. Potassium is present in all body tissues and is required for normal cell

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<sup>8</sup>Mayo Clinic, “electrocardiogram,” accessed January 3, 2023, <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983?p=1>.

<sup>9</sup> Merriam-Webster.com Dictionary, “epinephrine,” accessed May 15, 2020, <https://www.merriam-webster.com/dictionary/epinephrine>.

<sup>10</sup> Merriam-Webster.com Dictionary, “gait,” accessed September 29, 2022, <https://www.merriam-webster.com/dictionary/gait>.

<sup>11</sup> Johns Hopkins All Children’s Hospital, “Nutritional Services for Pediatric Gastrointestinal Conditions,” accessed May 14, 2020, <https://www.hopkinsallchildrens.org/Services/Nutrition/Pediatric-Gastrointestinal-Conditions>.

<sup>12</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*. October 31, 2018.

<sup>13</sup> VHA Handbook 1004.03(2).

<sup>14</sup> Elsevier, *Standardize Skills for Consistent Care*, “Orthostatic Vital Signs (Ambulatory),” June 30, 2022, accessed January 3, 2023, <https://elsevier.health/en-US/preview/orthostatic-vital-signs-ambulatory-ce>.

<sup>15</sup> VHA Directive 1190.

function because of its role in maintaining intracellular fluid volume and transmembrane electrochemical gradients.”<sup>16</sup>

**pulse oximeter.** “A small, clip-like device. . . to measure oxygen levels in the blood.”<sup>17</sup>

**pulseless electrical activity.** “A common occurrence during [cardiac] arrest situations” in which there is “electrical activity in the heart” on the AED monitor “but the patient will have no palpable pulse.”<sup>18</sup>

**root cause analysis.** “A process for identifying the basic or contributing causal factors that underlie variations in performance.”<sup>19</sup>

**sleep apnea.** “A potentially serious sleep disorder in which breathing repeatedly stops and starts.” The more common form is obstructive.<sup>20</sup>

**standard of care.** “The degree of care or competence that one is expected to exercise in a particular circumstance or role.”<sup>21</sup>

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<sup>16</sup> National Institutes of Health, Office of Dietary Supplements, “Potassium Fact Sheet for Health Professionals,” accessed September 30, 2022, <https://ods.od.nih.gov/factsheets/Potassium-HealthProfessional/>.

<sup>17</sup> National Institutes of Health/National Library of Medicine, “pulse oximetry,” accessed September 28, 2022, <https://medlineplus.gov/lab-tests/pulse-oximetry/>. “A normal oxygen saturation level ranges between 95 percent and 100 percent.”

<sup>18</sup> ACLS.net, “Pulseless arrest algorithm for managing PEA,” accessed March 13, 2019, <https://www.acls.net/acls-pulseless-arrest-algorithm-pea.htm>.

<sup>19</sup> VHA Handbook 1050.01.

<sup>20</sup> Mayo Clinic, “Sleep apnea: symptoms and causes,” accessed December 14, 2018, <https://www.mayoclinic.org/diseases-conditions/sleep-apnea/symptoms-causes/syc-20377631>.

<sup>21</sup> Merriam-Webster.com Dictionary, “standard of care,” accessed September 27, 2022, <https://www.merriam-webster.com/legal/standard%20of%20care>.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
<b>Inspection Team</b>	Susan Tostenrude, OT, MS, Director Erin Butler, LCSW Seema Maroo, MD Dawn Rubin, JD Nancy Short, LCSW Ann Ver Linden, RN, MBA
<b>Other Contributors</b>	Karen Berthiaume, RPh, BS Natalie Sadow, MBA Dawn M. Woltemath, MSN, RN

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